CHAPTER 77A

ADULT MENTAL HEALTH REHABILITATION SERVICES PROVIDED IN/BY COMMUNITY RESIDENCE PROGRAMS

Division of Medical Assistance and Health Services
ADULT MENTAL HEALTH REHABILITATION SERVICES PROVIDED IN/BY COMMUNITY RESIDENCE PROGRAMS
N.J.A.C. 10:77A
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SUBCHAPTER 1. GENERAL PROVISIONS

10:77A-1.1 Scope and purpose

(a) The subchapter sets forth the program standards pertaining to the provision of adult mental health rehabilitation services provided to New Jersey Medicaid/NJ FamilyCare-Plan A beneficiaries in/by community residence programs licensed under N.J.A.C. 10:37A.

(b) Adult mental health rehabilitation services support and encourage the development and maintenance of appropriate skills needed by the beneficiary to ensure successful living within the community, reducing or eliminating the need for inpatient psychiatric hospitalization.

10:77A-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Adult" means any individual who meets the Division of Mental Health Services' criteria for adult services, as defined in N.J.A.C. 10:37A.

"Community residences for mentally ill adults" as used in this chapter means any community residential program licensed by, and under contract with, the Division of Mental Health Services (DMHS) to provide services in accordance with N.J.A.C. 10:37A to mentally ill adults who require assistance to live independently in the community. "Community residences for mentally ill adults" does not include "Supportive housing residences" as the term is defined herein.

"Mental health rehabilitation services" means services provided in/by a community residence program licensed by the DMHS, which include, but are not limited to, assessment and development of a comprehensive service plan, and implementation of the service plan through individual services coordination, training in daily living skills and supportive counseling.

"Supportive housing residence" means any unit of dwelling space as defined at N.J.A.C. 10:37A-1.2.

10:77A-1.3 Provider participation

(a) In order to participate in the Medicaid/NJ FamilyCare program, all applicants shall be licensed by and under contract with the Division of Mental Health Services (DMHS) as a

community residence for mentally ill adults in accordance with N.J.A.C. 10:37A.

(b) All providers shall complete and submit the following documents, and shall update the documents when the information contained therein changes, for example, when a new license is issued and/or when any information on the FD-20 changes:

1. "Medicaid Provider Application" (FD-20);
2. "Medicaid Provider Agreement" (FD-62);
3. A copy of a current and valid license from the Division of Mental Health Services; and
4. "Disclosure of Ownership and Control Interest Statement" (CMS 1513).

(c) Providers shall submit the documents listed in (b) above to:

Division of Medical Assistance and Health Services
Office of Provider Enrollment
PO Box 712, Mail Code #9
Trenton, New Jersey 08625-0712

(d) A separate application shall be submitted for each county in which the provider renders services.

(e) The applicant will receive written notification of approval or disapproval of Medicaid/NJ FamilyCare provider status from the Division of Medical Assistance and Health Services (DMAHS). If approved, the applicant will be assigned a Medicaid/NJ FamilyCare Provider Number, and will receive a copy of this chapter as part of the provider manual. Each provider agency shall be assigned a unique provider number for each county in which services are provided.

(f) The DMHS will certify to the DMAHS the level of care and the number of beds and separate sites for each agency.

(g) If an adult mental health rehabilitation services provider loses its license from DMHS, the provider shall notify the DMAHS Provider Enrollment Unit, at the address in (c) above, within five business days of losing the license.

1. The adult mental health rehabilitation provider will be disenrolled as a Medicaid/NJ FamilyCare provider until such time as the license is restored. Once DMHS restores the provider's license, the provider, upon providing proof of the restoration of the license to the provider enrollment office noted above, will be reinstated as a Medicaid/NJ FamilyCare provider as long as the requirements of N.J.A.C. 10:37A and this chapter are met and continue to be met. The effective date shall be the date of reinstatement as determined by DMHS licensing standards.
2. The adult mental health rehabilitation provider may be held liable for recoupment of any monies paid for services during the time that they did not possess a valid license or a valid

license for the specific site at which the services were provided, for all services reimbursed.

10:77A-1.4 Beneficiary eligibility

(a) Medicaid/NJ FamilyCare-Plan A beneficiaries shall be eligible for adult mental health rehabilitation (AMHR) services provided in/by community residence programs, if such services have been determined clinically necessary using the criteria established by the Division of Mental Health Services (see N.J.A.C. 10:37), or as authorized by any contracted agent of the Department of Human Services which authorizes clinical need for mental health services for adults.

(b) NJ FamilyCare-Plans B, C, D, G and H beneficiaries are not eligible for AMHR services provided in/by community residence programs.

(c) Beneficiaries eligible as "medically needy" in accordance with N.J.A.C. 10:71 shall not be eligible for AMHR services provided in/by community residence programs.

END OF SUBCHAPTER 1

SUBCHAPTER 2. PROGRAM OPERATIONS

10:77A-2.1 Program requirements

(a) Adult mental health rehabilitation (AMHR) services provided in/by community residence programs to Medicaid/NJ FamilyCare/ CSOCI beneficiaries shall meet all program and licensure requirements contained in N.J.A.C. 10:37A, Community Residences for Mentally Ill Adults.

(b) AMHR services shall include, at a minimum, but are not limited to:

1. Assessment and evaluation;
2. Individual services coordination;
3. Training in daily living skills;
4. Residential counseling;
5. Support services; and
6. Crisis intervention counseling services.

(c) All AMHR services shall be provided directly by, or under the direction or coordination of, agency staff.

10:77A-2.2 Levels of care

(a) Level A+ means community mental health rehabilitation services available in the community residence, or in a community setting, 24 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis.

(b) Level A means community mental health rehabilitation services available in the community residence or in a community setting at least 12 hours per day, but less than 24 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis.

(c) Level B means community mental heath rehabilitation services available in the community residence, or in a community setting, at least four hours per day, but less than 12 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis for AMHR Level B services rendered in a group home setting. Reimbursement shall be provided for complete quarter-hour units of service for AMHR services rendered in a supervised apartment setting.

(d) Level C means community mental health rehabilitation services provided in the community residence or in a community setting a minimum of one hour per week, delivered by the provider. Reimbursement shall be provided for complete quarter-hour units of service.

(e) Level D means community mental health rehabilitation services available in the community residence, in residences not to exceed five residents, or in a community setting, 24 hours per day, delivered by the provider.

10:77A-2.3 Nursing assessments

(a) Upon admission to an adult mental health rehabilitation community residence program, all beneficiaries shall receive a comprehensive nursing assessment, completed by a registered nurse, or higher level nursing professional, in addition to any and all assessments required by N.J.A.C. 10:37A.

(b) The initial nursing assessment shall be completed within 14 calendar days of admission, as follows:

1. The initial nursing assessment shall justify the need for continued mental health rehabilitation services and shall include a recommendation for an appropriate level of service; and
2. The initial nursing assessment shall be used in conjunction with the comprehensive intake assessment to develop the comprehensive service plan as required in N.J.A.C. 10:37A.

(c) A registered nurse, or higher level professional, shall conduct a review at least every 60 days for each beneficiary receiving AMHR services. The review conducted shall consist of a face-to-face visit, which shall include an assessment of the beneficiary's clinical condition and a review which shall assure that services are being provided consistent with the beneficiary's comprehensive service plan. During each visit, the reviewer shall, at a minimum:

1. Review the service plan;
2. Review the observations and progress notes made by the direct care staff;
3. Assess the client's health; and
4. Indicate any changes needed in treatment approaches in the service plan.

(d) Comprehensive nursing reassessments shall be completed on at least an annual basis and shall include a justification for the continuation of services and a recommendation for the appropriate level of care.

1. Nursing reassessments shall be completed upon any significant positive or negative change in the condition of a beneficiary which may warrant a permanent or temporary change in the level of care rendered to the beneficiary.

(e) All nursing assessments, reassessments and supervisory follow up visits shall be performed in the beneficiary's residence and shall be related specifically to mental health rehabilitation services. Nursing reassessments shall indicate progression or regression relative to the beneficiary's condition and treatment goals.

(f) All beneficiaries determined to need community mental health rehabilitation services shall be placed in the least restrictive and most effective level of care which will meet their needs.

(g) If the beneficiary is determined to need a lesser level of care than the group home or supervised apartment he or she is residing in is licensed to provide, the providers shall only bill

for the lower level of care needed and provided.

10:77A-2.4 Staff training

(a) All providers shall comply with the general training requirements prescribed by the Division of Mental Health Services (DMHS) at N.J.A.C. 10:37D-2.14.

(b) In addition to the general training requirements at N.J.A.C. 10:37D- 2.14, each provider shall develop, update and administer a comprehensive, competency-based training program for individuals providing adult mental health residential services. Competency based training programs involve measurable skill development and demonstrated, documented evidence of employee skill attainment. The DMHS will be responsible for monitoring the provider's training programs. The following topics, at a minimum, shall be included in the training curriculum:

1. Overview to adult mental health rehabilitation services, including, but not limited to:
   i. Psychiatric rehabilitation;
   ii. Resident populations;
   iii. Working with persons with mental illness;
   iv. Continuum of care and discharge orientation;
   v. Professional ethics and boundaries; and
   vi. Confidentiality;
2. Emergency preparedness, including, but not limited to:
   i. CPR/first aid;
   ii. The Heimlich maneuver;
   iii. Crisis prevention and management; and
   iv. Infection control;
3. Medication/clinical issues, including:
   i. Policies and procedures for distribution and facilitation of the administration of prescription and non-prescription medication;
   ii. Classes of medication, therapeutic objectives, side effects, interactions; including documentation and reporting of side effects to appropriate medical professional;
   iii. Facilitation of proper administration techniques, including dispensing and observation; and
   iv. Clinical communication (including how to report symptoms when encountering problematic medical/clinical situations and pertinent information to share with medical providers during emergencies);
4. Substance abuse issues in conjunction with mental illness;
5. Suicide prevention, including, but not limited to, risk factors and warning signs;
6. Activities of daily living and personal care management, including, but not limited to:
   i. Personal hygiene;
   ii. Food preparation and nutrition;
   iii. Household maintenance, laundry budgeting; and
   iv. Monitoring of prescribed individual eating modifications; and
7. Documentation, including, but not limited to:
   i. Daily attendance logs where applicable (for programs reimbursed on a per day basis);

ii. Daily recording of nature of services rendered, including the total number of units of service provided;
iii. Weekly progress notes; and
iv. Objective versus subjective recording of information.

(c) All individuals who provide AMHR services, other than a psychiatrist, regardless of credentials, shall have completed the training required by (a) and (b) above in order for their service time to be counted toward the minimum service requirements necessary for Medicaid/NJ FamilyCare-Plan A reimbursement.

(d) Individuals who are delivering services who have not completed the required training shall not deliver services alone. Such individuals shall be supervised by, and shall deliver the services in conjunction with, a trained person who is on-site and provides in-person supervision.

10:77A-2.5 Basis of reimbursement

(a) Reimbursement for AMHR services provided in or by community residence programs to eligible Medicaid and NJ FamilyCare-Plan A beneficiaries shall be based on the site-specific levels of care delivered by each provider, in accordance with this chapter.

(b) Reimbursement will be on a fee-for-service basis for each level of care, billable in either per-diem or quarter-hour units of service as applicable and as enumerated in this chapter and the billing supplement to this chapter. The rates shall be all-inclusive and shall be based on the range of services included in the service definition. The fee shall not include non-treatment and/or non-rehabilitation-related services, including, but not limited to, room and board, recreational and vocational services.

(c) Providers will be reimbursed on a per diem basis for services provided by all Level A+, A and D programs and those Level B programs that are group homes.
1. Providers shall seek reimbursement only for the dates that the beneficiary:
i. Received services;
ii. Was documented as being under the care of the facility; and
iii. Was physically present in the facility during at least part of the 24- hour period starting and ending at midnight.
2. Providers may seek reimbursement for services provided on the date that the beneficiary is admitted to the facility, but shall not seek reimbursement for services provided on the beneficiary's date of discharge.
i. The beneficiary's discharge date shall be the date the beneficiary is expected to permanently leave the residence. The discharge date shall not include dates that the beneficiary leaves, but is expected to return, including, but not limited to, absences due to vacations, visits with family, or temporary hospitalization.
3. Providers may bill for consecutive dates of service on the same billing form line, but shall

not span dates from more than one calendar month on the same billing form line and shall not include in the consecutive dates of service any dates that a resident was not physically present.

(d) Providers shall be reimbursed for quarter-hour units of service for rendering services at all Level C programs and at those Level B programs that are supervised apartments. A quarter-hour unit of service is defined as 15 consecutive minutes of service.

1. Providers who bill in quarter-hour (15 minute) units shall complete a separate claim line on the CMS 1500 for each separate date on which services were provided and shall indicate the total number of units of service that were provided on that day.
2. Non-consecutive shorter time periods shall not be added together to total 15 minutes.
3. Non-consecutive multiple complete units of service rendered on the same day, when provided in accordance with this chapter, will be reimbursed.

(e) Medicaid/NJ FamilyCare reimbursement will not be provided for both mental health personal care assistant (PCA) services and AMHR services provided in or by a community residence program for the same beneficiary on the same date of service. Medical or physical PCA services rendered to a beneficiary will be reimbursed, if all other applicable requirements are met.

(f) Medicaid/NJ FamilyCare reimbursement will not be provided for Programs of Assertive Community Treatment (PACT) services provided to the same beneficiary on the same date of service.

(g) If a beneficiary is required to remain in a residence while awaiting transfer to a more appropriate facility (see N.J.A.C. 10:77A-2.5), the provider shall request reimbursement at the lesser of:

1. The level of service approval for the site; or
2. The level of care which the resident requires.

10:77A-2.6 Recordkeeping

(a) All community residences for mentally ill adults shall keep such legible records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for such services, and the place, date and the total units of service that were provided.

(b) Recordkeeping for AMHR services shall include clinical records and reports for each individual beneficiary. These reports shall cover the medical, nursing, social and health-related care rendered to the beneficiary, in accordance with accepted professional standards.

(c) The provider shall maintain, at a minimum, the following documentation in support of all claims for payment:

1. The name of the beneficiary;
2. The date(s) of service(s);
3. The type(s) of service(s) provided;
4. The name of the residential program providing the service and the specific location that the service was provided; and
5. Appropriate service documentation:

i. For services reimbursed on a per diem basis, documentation shall include a daily census of the residence and proof of staffing levels consistent with the level of care.

ii. For services reimbursed on a per quarter-hour basis documentation shall include the time of arrival and departure of the staff member, the total amount of time the Medicaid-reimbursable service(s) were provided, the name(s) of the staff rendering the service(s) and the name of the resident(s) receiving the service(s).

(d) All records shall be made available upon request to representatives of the Department of Human Services or its authorized agents.

END OF SUBCHAPTER 2

SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:77A-3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare programs use the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. The CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical procedures and services performed by physicians. Unlike the CPT numeric design, the CMS assigned codes and modifiers may contain alphabetic characters.

(b) HCPCS is a three-level coding system, as follows:

1. LEVEL I CODES (narratives found in the CPT): These codes are adapted from the Physicians Current Procedural Terminology, as amended and supplemented, published by the American Medical Association, 515 N. State Street, Chicago, IL 60610, incorporated herein by reference. The CPT codes are used primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners/clinical nurse specialists, independent clinics and independent laboratories. Copyright restrictions make it impossible to print substantial excerpts from CPT procedure narratives for Level I codes. Thus, in order to determine those narratives, it is necessary to refer to the CPT.
2. LEVEL II CODES: The narratives for Level II codes are found in this subchapter. These codes are not found in the CPT and are assigned by CMS for use by physicians and other practitioners.
3. LEVEL III CODES: The narratives for Level III codes are found in this subchapter. These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services that are unique to the New Jersey Medicaid/NJ FamilyCare programs.

(c) Regarding specific elements of HCPCS codes which require the attention of providers, the lists of HCPCS code numbers for services are arranged in tabular form with specific information for a code given under columns with titles such as "HCPCS Code," "DESCRIPTION" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. "HCPCS Code"--Lists the HCPCS procedure code numbers;
2. "DESCRIPTION"--Code narrative: Narratives for Level III codes are found at N.J.A.C. 10:77A-2.2;
3. "MAXIMUM FEE ALLOWANCE"--Lists the New Jersey Medicaid/NJ FamilyCare programs' maximum fee allowance schedule. If the symbol "B.R." (By Report) is listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbol "N.A." (Not Applicable) is listed instead of a dollar amount, it means that the service is not reimbursable.

(d) Alphabetic and numeric symbols under "IND" and "MOD": These symbols, when listed

under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed and any additional parameters required for reimbursement purposes.

1. Providers shall consider these symbols and/or letters when billing because the symbols/letters reflect requirements, in addition to the narrative that accompanies the CPT/HCPCS procedure code, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

(e) The general and specific requirements of the New Jersey Medicaid/NJ FamilyCare program that pertain to HCPCS follow:

1. When filing a claim, the appropriate HCPCS Codes shall be used in conjunction with modifiers, when applicable;

2. The use of a procedure code shall be interpreted by the New Jersey Medicaid/NJ FamilyCare programs as evidence that the provider furnished, as a minimum, the service for which it stands;

3. When billing, the provider shall enter onto a CMS 1500 claim form, a CPT/HCPCS procedure code as listed in CPT or in this subchapter.

4. Date(s) of service(s) shall be indicated on the claim form and in the provider's own record for each service billed;

5. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum amount a provider will be reimbursed for the given procedure;

i. All references to time parameters shall mean the provider's personal time in reference to the service rendered, unless otherwise indicated. These procedure codes are all-inclusive for all procedures provided during that time;

6. Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the Division of Medical Assistance and Health Services, the Department of Human Services, or any contracted and authorized agent of the Department.

10:77A-3.2 HCPCS codes and maximum fee allowance schedule for adult mental health rehabilitation services provided in/by community residence programs

HCPCS CODE	MOD	DEFINITION	MAXIMUM FEE ALLOWANCE
Z7333		Adult MH Rehab. Svcs. Level A+ Group Home (per diem)	$164.00
Z7333	52	Adult MH Rehab. Svcs. Level A+ Supervised Apartment (per diem)	$164.00
Z7334		Adult MH Rehab. Svcs. Level A Group Home (per diem)	$131.00
Z7334	52	Adult MH Rehab. Svcs. Level A Supervised Apartment (per diem)	$66.00
Z7335		Adult MH Rehab. Svcs. Level B Group Home (per diem)	$102.00
Z7335	52	Adult MH Rehab. Svcs. Level B Supervised Apartment (per 15 minutes)	$3.75 ($15.00/hour)
Z7336		Adult MH Rehab. Svcs. Level C Group Home (per 15 minutes)	$3.75 ($15.00/hour)
Z7336	52	Adult MH Rehab. Svcs. Level C Supervised Apartment (per 15 minutes)	$3.75 ($15.00/hour)
Z7337		Adult MH Rehab. Svcs. Level D (per diem)	$40.00

END OF SUBCHAPTER 3